

OFFICE OF SUBSTANCE ABUSE (DHHS)
159 State House Station, Augusta ME 04333-0159
Fax 207-287-4345 Voice 207-287-4396

Critical Incident Reporting Form

Licensed or contracted agencies are required to report critical incidents to OSA (14-118 CMR Ch 4, Section 4.04 N). Answer all questions completely and thoroughly, attaching additional sheets as necessary. The examples of incidents provided are not all-inclusive. Programs are expected to exercise good judgment in reporting all serious and significant incidents.

PLEASE LEGIBLY PRINT OR TYPE ALL INFORMATION.

<u>Name of Agency/Facility</u>	<u>Address</u>	<u>Telephone</u>
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CHECK THE CORRECT BOX TO CATEGORIZE THE INCIDENT

<p style="text-align: center;"><u>Level I Incidents</u></p> <p>Level I incidents are events that result in death or serious injury or significantly jeopardize clients, public safety, or program integrity. Level I incidents occurring to clients must be reported to OSA <u>whether or not they occur at the program site</u>. They must be reported by phone to OSA within 4 hours after the incident becomes known to staff and followed by a faxed incident report within one business day.</p> <p><input type="checkbox"/> A. Suicide/suicide attempt</p> <p><input type="checkbox"/> B. Homicide</p> <p><input type="checkbox"/> C. Other death</p> <p><input type="checkbox"/> D. Major physical plant disaster</p> <p><input type="checkbox"/> E. Other serious event. Describe _____</p> <p>_____</p>	<p style="text-align: center;"><u>Level II Incidents</u></p> <p>Level II incidents include significant errors or undesirable events that compromise quality of care or client safety. They must be reported by phone to OSA within 4 hours after the incident becomes known to staff and followed by a faxed incident report within one business day.</p> <p><input type="checkbox"/> A. Major medication error or other adverse clinical event resulting in the need for immediate/emergency medical attention</p> <p><input type="checkbox"/> B. Alleged physical and/or sexual abuse of a client by a staff member or by another client, a report of physical or sexual abuse filed with DHHS</p> <p><input type="checkbox"/> C. Other significant event. Describe _____</p> <p>_____</p>
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Date and time incident occurred: _____ **Client Identifier (TDS):** _____ **Gender:** Male ____ Female ____ **Age:** _____

Current status of all persons involved: _____

Names of staff involved: _____

What follow-up is planned? _____

Incident description: (Answer all questions in detail. Attach additional sheet if necessary)

What happened?

Staff Response: (Use Categories below; include specific actions taken by agency/facility & person(s) involved in response)

1. Actions taken to ensure client safety:

2. Was medical attention required by any person? (Provide details on an additional sheet if necessary)

3. What was the administrative response?

Signature of Staff Person Completing Report

Date

Printed Name

Signature of Supervisor Reviewing Report

Date

Printed Name

FOR OSA USE:

OSA Signature _____ date received _____

time received _____

a. Appropriate and immediate response? (Y/N)

b. Treatment Team review initiated? (Y/N) If yes, date requested: _____

c. Sentinel review initiated (Y/N) If yes, date requested: _____

d. Follow-up needed? (Y/N)

Routing: __ OSA Director __ Treatment Team Mgr. __ Licensing Director __ Medical Director Other _____